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Medicaid's Tenth Year ■ Program Summary ■ State News ■ Child Foster Care ■ Medicaid QC ■ Research and Demonstrations

Social and Rehabilitation Service UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Volume 2/Number 4/May 1975

Like Mother Like Daughter

Mommy beat up daughter. Now daughter is beating up dolly. It's so easy for a child abuser to create another generation of child abusers.

How do you put an end to this grim equation? By helping both children. The daughter. And the mother.

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THE SOCIAL AND REHABILITATION
Record

Volume 2, Number 4

May 1975

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Caspar W. Weinberger, Secretary

James S. Dwight, Jr.
Administrator, Social and Rehabilitation Service

Robert A. H. Wilson
Assistant Administrator for Public Affairs

EDITORIAL STAFF

William G. Newkirk, Director, Editorial Services
Robin A. Atkiss, Art Director
Patricia U. Fells, Managing Editor

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California studies problem areas in administration of AFDC program

The California Department of Benefit Payments has instituted the County Operations Improvement Study which utilizes two specialized State groups to simultaneously review active AFDC cases and identify error trends and perform a systems review of AFDC operations.

Through this approach California hopes to identify problem areas in the Department of Benefit Payments' administration of the AFDC program, as well as in specific counties' AFDC operations.

Analysts involved with the study will develop and recommend solutions to these problems, establish valid and useful data on specific counties' error rates, and identify the positive aspects of a particular county's operation which may be helpful to other county systems.

Following the study and after completion of the final report, staff members of the Department of Benefit Payments will be made available to the county to assist in implementing the recommendations. A followup study is planned to determine the status of the recommendations, to measure the effectiveness of the recommendation implemented, and to evaluate the study approach and methods.

New reporting system improves eligibility determination in AFDC

The California Department of Benefit Payments has developed a one-page form which will provide a monthly update to the pertinent county welfare department of factors which may determine AFDC eligibility and/or affect the amount of the grant.

This form, replaces a system requiring the recipients to report to the county welfare board either four or two times a year depending on the type of benefits received and to complete a 12-page form. With the new form, recipients report changes during the report month as well as any expected changes which would affect continuing eligibility.

The new monthly report system is expected to result in more accurate determination of AFDC eligibility and of the amount of the grant, be more convenient for recipients, make more efficient and effective the eligibility determination operations of county welfare departments, and be cost beneficial to the county, State, and Federal governments.

Health care facilities lobby organizations to report on spending

The Acting New York State Health Commissioner has asked the associations that represent nearly all of the 1,200 nursing homes, hospitals, and health care facilities in the State to provide reports on how they spend their money.

This information would document expenses incurred by the association for lobbying, advertising campaigns, litigation, and other activities. To the extent that association expenses fail to meet Federal reimbursement criteria—being reasonably related to the "efficient production" of health care—the amount of dues allowable under Medicaid might accordingly be reduced.

The Department of Health, which has the authority to decide which expenses are reimburseable, has already made it known that nursing homes may no longer bill Medicaid for legal fees incurred in suing State or in defending themselves while under investigation.

Calif. DVR enters rehab agreement with Southern Pacific

The California Department of Rehabilitation and the Southern Pacific Transportation Company have embarked on a cooperative project to rehabilitate disabled Southern Pacific employees.

The project, being conducted experimentally for 6 months, is an outgrowth of Southern Pacific's "Rehabilitation Team," established over a year and a half ago. The team consists of a project manager, a chief medical officer, a medical officer, an assistant general claims manager, and a vocational rehabilitation counselor attached to the Bay Area Region staff.

The project is designed to help the disabled individual return to a Southern Pacific job, if at all possible, and at the same time help the company retain the services of experienced employees.

The team has processed over 300 cases of employees disabled through on or off duty injuries and illnesses. It has been able to help 100 of them get back to work again, either with Southern Pacific or other employers.

The rehabilitation team works principally through fact-finding panels on each of the company's nine divisions and on the Cotton Belt. The panels identify employees needing services of the team and get the process moving as soon as possible after the employee's injury or illness. The panel stays in touch with the employee during convalescence. Disabled

employees are also referred by supervisors and union officers. The employee is then referred to the Department's statewide coordinator for the program who places the case with a selected vocational rehabilitation counselor nearest the client's home. Medical treatment or other medical services, as needed, are provided by Southern Pacific.

Five Virginia areas to test integration of service delivery

The Governor of Virginia has selected five localities as "517 projects"—pilot projects designed to test approaches to the integration of human service delivery.

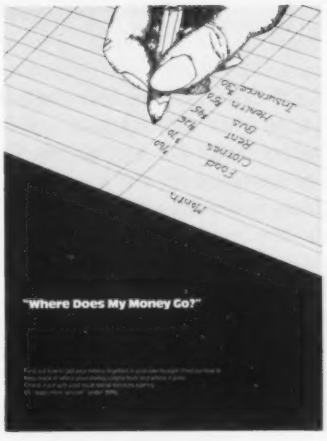
The projects will attempt to provide citizens with services and assistance relating to their physical, mental, and economic needs in a comprehensive manner.

Under Senate Bill 517, which empowers the Governor to make these selections, the Governor is granted the power to waive certain State rules and policies that might inhibit implementation of the projects.

Senate Bill 517 and the pilot projects developed from an SRS-funded research and demonstration project—the Richmond, Va., Services Integration Targets of Opportunity (SITO) Project (18-P-56666). The Division of State Planning and Community Affairs (the SITO grantee) will provide technical assistance to all localities in carrying out these programs.

Areas selected for participations are the counties of Fairfax and Carroll, and the cities of Roanoke, Hampton, and Chesapeake. Designated as alternates are Charles City, Washington, Montgomery, and Arlington counties.

FREE WAYS TO WIN PEOPLE AND INFLUENCE FRIENDS



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The RECORD Talks to the Experts

Medicaid's Tenth Year— What's Been Accomplished?

The Medicaid program is 10 years old this year, and to find out where the program is, what it has accomplished, and where it is going, THE RECORD talked with Dr. Keith Weikel, Commissioner of the Medical Services Administration in the Social and Rehabilitation Service.

QUESTION: Dr. Weikel, with Medicaid in its 10th year, what has been accomplished in that time?

DR. WEIKEL: Well, obviously the greatest accomplishment of the program is the fact that during those 10 years many of our lower income citizens have received medical services that they probably would not have received without a Medicaid program. We are now providing services to somewhere in the neighborhood of 25 million lower income citizens each year. And throughout the history of the program we have provided services to a very large number of lower income Americans. We have not only given them services but probably provided a broader range of services than they would have received without the Medicaid program.

But beyond the simple provision of services, I think Medicaid has made a contribution toward innovative concepts in financing health programs. For example, I think the Medicaid program has been much more innovative than other health care financing programs in such areas as methods to control costs and effective utilization review programs.

Medicaid has been involved with the development of some of the first projects. I think of the San Joaquin Medical Foundation, the Sacramento Medical Foundation, and the New Mexico Medical Foundation, which developed and is carrying out the utilization review for the New Mexico Medicaid program.

Another area where I think there has been a lot of innovation is in encouraging the States to establish HMOs or prepaid health plans for their recipients. We've been much more aggressive in this than Medicare has been. There are some problems with prepaid health plans when you try to get into them too rapidly, and there have been some abuses. But we are now working on regulations aimed at preventing abuse in the future. These are just some of the areas where Medicaid has shown very significant accomplishments.

QUESTION: Is there anything else that you wish Medicaid had been able to do?

DR. WEIKEL: Well, there are a lot

of shortcomings in the Medicaid program. I am very concerned that we haven't been more efficient in the administration of the program. I'm concerned about the amount of alleged fraud and abuse that takes place in the Medicaid program. I'm concerned about the image of the Medicaid program. We get a lot of very poor press about the abuses that take place.

QUESTION: Who is abusing the program? Is it the patients? The vendors? The administrators? Hospitals?

DR. WEIKEL: Well, there's abuse on the part of a number of groups involved in the Medicaid program. There is abuse on the part of some of the recipients. One of the programs we are developing now—the Medicaid Eligibility Quality Control program—is to get at the problem of ineligible recipients who are receiving Medicaid services. We also hear about recipients who pass their Medicaid cards to friends to purchase services. We need to address that problem.

However, of much greater concern to us as administrators of the program are the abuses that are taking place on the part of providers, whether they be

nursing homes, physicians, pharmacists, or anyone else.

We believe there are some practices of overprescribing or overutilization of services that we would classify merely as abuse, and we must rely on the providers to assist us in reducing that. But other practices that have been reported are clearly fraudulent, and those we must move on rapidly.

We believe we need to develop systems that will allow us to routinely identify cases of suspected provider fraud so that these can be acted upon quickly and if necessary referred for prosecution. The whole area of provider fraud and abuse is one of the priority areas we plan to tackle within the next year.

QUESTION: One of the things you have been pushing very strongly is the early and periodic screening, diagnosis, and treatment program for children under 21. Is it going as well as you had hoped? Do you think the States really are trying to improve? Is MSA giving them enough of the kind of help they need?

DR. WEIKEL: Well, really, the EPSDT program is not moving as rapidly as I want, nor as rapidly as the Administrator or the Secretary would like to see, nor as rapidly as most other people who are interested in this program would like to see.

We got off to a very slow start and it has been very difficult to speed up the implementation of this program. One reason is that this is the first time we have required the Medicaid programs in the States to do anything more than administrate payments to providers for services. For the first time they have been required to arrange for the provision of services to an entire, defined group of people—all needy children under 21.

Neither the States nor the Federal Government have had much experience in this kind of effort. There is a real need for an outreach component in the early and periodic screening and treatment program, not as a legal requirement per se, but in order to get an individual in for screening and treatment and to have appropriate followup.

QUESTION: Are the States really doing any outreach?

DR. WEIKEL: Some of the States are, but it's very spotty. It is one of the areas that needs the most work. The number of children we have screened is still small—less than 3 million. And those we have not yet screened will be much more difficult to reach. Reaching them is going to require a much more aggressive program, in-

cluding more aggressive outreach services.

But the principal objective that we see for the whole program is finally to get the children treated after they've been screened—to be sure that any conditions identified are taken care of. We want the children drawn into the traditional medical care or medical delivery system. That's important. We don't believe that Medicaid recipients and children who should be getting EPSDT services should have to resort to the outpatient department or the emergency room of a hospital. They should be seen within the traditional medical care system, whether that be a prepaid health plan or a fee-for-service provider.

You asked whether the States are trying to improve the program. I think interest on the part of the States in improving the program has increased since the summer of '74. But are they doing enough? Are any of us doing enough? Until we get more of the children screened and treated, the answer to those questions is clearly no.

Now you asked about technical assistance. The Federal Government has so far provided very limited technical assistance. But we are gearing up and hiring more people for this purpose. We are also working at the regional level to involve other parts of the Department such as the health side and the Office of Human Development—in trying to pull all the aspects of this program together at the local level. We have involved some of the professional organizations—such as the American Academy of Pediatrics, the American Dental Society—in providing professional advice and developing manuals and guidelines. That's important, because we are not equipped to provide alone all the technical assistance the States need. There are many other groups, especially the professional societies, that can help out. We are also considering contracts with some of these groups to help the States in the technical assistance area.

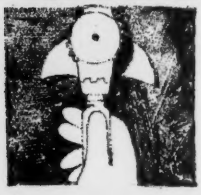
QUESTION: During the conversation, you have said two things that seem to substantiate charges that the Medicaid program doesn't live up to its promises. You've said that, despite 10 years of Medicaid, children the program is suppose to help are still for the most part outside the traditional medical care system. Then you said that the States are not doing enough. The Congress voted to penalize States that don't do what they are supposed to about EPSDT, and yet the penalty hasn't been applied. Why is it taking so long?

DR. WEIKEL: Our first penalty is going to be assessed for the first quarter of fiscal year 1975. It has taken so long because, first of all, we couldn't begin making determinations of State effort until October 1. And second, we didn't have enough staff to get out rapidly to visit each of the States. We have to do administrative reviews or onsite assessments in six counties in each State in order to make a penalty determination. The procedures one has to go through to assess penalties require a long time—too long in my opinion. I think we should be able to make these penalty assessments much more rapidly after the end of each quarter. And I believe that within the next 6 months we will be in a somewhat better position to do that.

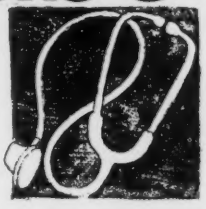
QUESTION: What about nursing homes, Dr. Weikel? The papers lately have been filled with stories about scandals and fraud in nursing homes. There are charges that many nursing homes don't meet Federal requirements for safety or even for services. How is Medicaid involved in surveying and monitoring homes and why are so many of them still below standards?

DR. WEIKEL: Well, first of all, surveying the homes is really the responsibility of State Government and within States, the responsibilities for surveying and for Medicaid are often

Children should be seen.

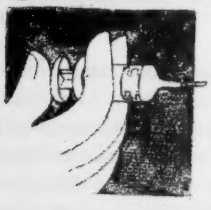


And heard.

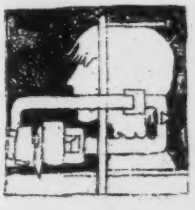


And ahhh'd.

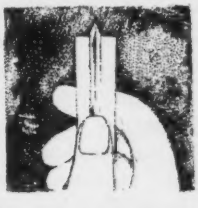
And needled.



And measured.



And tested.

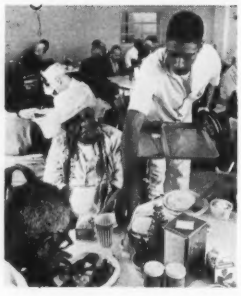


And charted.

And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.



lodged in different departments. In many States the health department has responsibility for surveying but not for the Medicaid program, and within HEW, the certification program for nursing homes is the responsibility of the Office of Nursing Home Affairs and the Special Assistant to the Secretary for Nursing Home Affairs, not the Medical Services Administration. The Department has just conducted a survey of 300 homes to determine whether or not they are meeting standards and that data is being analyzed now. But the Medical Services Administration is not directly involved in nursing home certification at either the State or Federal levels.

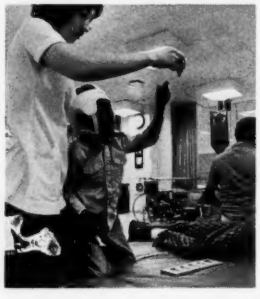
However, I believe that we must develop a much more active program within MSA for long term care. We are now reestablishing a Division of Long Term Care. I certainly hope that 2 or 5 years from now we will not hear the same charges about patients living in unsafe homes or patients not receiving services when Medicaid is paying the bill.

I see the Long Term Care Division serving as a link between MSA, the Office of Nursing Home Affairs, and the long term care staff in the Regional Offices. MSA will then know exactly what is going on, at any time, in terms of the quality of care and the services provided in facilities participating in the Medicaid program. Beyond that I believe that a very important function of the Long Term Care Division will be to develop effective systems to monitor reimbursement practices and detect abuses in the reimbursement of long term care facilities. I am talking about things like the sale and resale of facilities and the charging of inappropriate costs to the Medicaid program.

QUESTION: You know there is general agreement that many elderly people would be happier if they could remain in their own homes instead of being sent to institutions. Do we have the wide range of home-related health services and other services that are needed to make this possible?

DR. WEIKEL: Well, as the Commissioner of Medicaid, I am very concerned about the fact that home-health services of all types are not used more. We are spending 35 percent of our dollars on long term care facilities and less than two-thirds of 1 percent on home-health services. That piece of information clearly tells me that we are not using the alternatives that do exist. If alternatives to institutionalization were more readily available, we probably could reduce expenditures on long term care facilities. Now to do that, we must have an aggressive program to encourage home-health services.

We are revising our regulations on home-health services for Medicaid. In the past we used the same language that was used in the Medicare regulation to define a home-health agency. Medicare says that a home-health agency has to provide the basic services of skilled nursing care, plus at least one auxiliary service such as



speech therapy or physical therapy. That requirement to provide auxiliary services may have eliminated somewhere between 500 and 700 community nursing associations from participating in the program.

We are proposing to change that. One part of our plan to increase use of home-health services is to make more agencies eligible to participate. We are also going to remove the prohibition that barred "for profit" agencies from providing home-health services in many States. Currently "nonprofit" agencies can participate in a Medicaid program if a State does not license home-health agencies, but a "for profit" agency can't. So that we don't have a lot of substandard agencies, we are also proposing a set of standards

that both profit and nonprofit agencies would have to meet, regardless of whether there is licensure within a State.

Those are some steps we are taking. In addition, we are involved with the Administration on Aging in experimentation in areas such as day care and day hospitals for the elderly.

We are involved in some demonstrations with community care organizations. These organizations provide someone in the community who is responsible for making sure that the elderly have appropriate services available to them if they are living in their homes, and receive physician visits, or a visiting nurse, or physical therapy as necessary. And someone is responsible for coordinating all of the resources in the community regardless of whether they

are provided with local, State, or Federal funds.

Someone makes sure that an individual receives meals if they are unable to do their own cooking. The Meals on Wheels program is one example of that type of thing.

We think we need to encourage the States to do that more than they are. Not all those services coordinated by the community care organization are paid for by Medicaid. But Medicaid does reimburse for services provided by home-health aides who provide services that a patient needs in his home.

QUESTION: Do State Administrators have to wait for a new regulation before they can speed the development of home-health services?

DR. WEIKEL: Definitely not. I think the States can have a more liberal attitude and more liberal policy in terms of encouraging home-health services, and we certainly are encouraging States to do that. I should point out, though, to provide fair balance, that we don't believe we should provide home-health services at any cost. We don't think it should cost more to keep an individual in his home environment than it costs to pay for his institutionalization.

QUESTION: What else should State Administrators be working on now?

DR. WEIKEL: Well, we feel very strongly that State Administrators should be trying to make the administration of the entire Medicaid program more efficient. They should put more efficient claims payment processes in place. They should have better systems in place to do surveillance and utilization review. They should have better management reports available. And they should develop good relationships with providers so that an adequate number participate in the program.

Another area the States need to do additional work in is the whole area of fraud and abuse I spoke about earlier. We think this critical, what with the expenditures in this program increasing at a very rapid rate and the number of recipients continuing to increase. We believe one of the ways States can continue to provide services to all the recipients who are eligible is to eliminate or reduce overuse of services—overutilization, overprescribing, whether it's drugs or clinical laboratory tests.

QUESTION: Are you saying that money can be saved without cutting services to people?

DR. WEIKEL: Yes. I think that in a program of this type when you are having fiscal problems the first inclination is to cut back services. That's one approach and it will save dollars. But we believe very strongly that one can bring about savings in the program without cutting services, by working for more efficient administra-

tion of the program and by developing systems to prevent fraud and abuse.

QUESTION: With some form of national health insurance apparently in the future, what are the aspects of Medicaid that you hope national health insurance planners will pay attention to?

DR. WEIKEL: Well, the thing that concerns me when I look forward to national health insurance is that Medicaid still has many problems—ineligible recipients, overutilization of services, overprescribing of services by providers, slow payment, fraud, I can give you a whole list. All these problems will be experienced many times over in a national health insurance program. I think we have to solve them first in Medicaid, which is a much smaller program than national health insurance will be. That's what the planners must look at in designing national health insurance, or we're going to have the same problems. I think the planners tend to say, "Well, we have all those problems with Medicaid, let's just design a new program called National Health Insurance and get rid of them." I believe very firmly that they'll end up with the same set of problems we have in Medicaid.

Now we can design some of them out of NHI. For example, some people argue that one of the problems we have is that we have assets tests, we have income tests, we have a lot of other eligibility requirements—the categorical relationship. There are a lot of individuals who are obviously in need of medical services but aren't categorically related. We can also have a uniform benefit package, rather than benefits that vary from State to State. We can design that kind of problem out of a national health insurance program. But there are a lot

of administrative problems in terms of claims processing, in terms of utilization review, in terms of developing appropriate types of regulations, that we can't design out right now.

QUESTION: One of the problems State officials say they are having is complaints from physicians and dentists about the amount of paperwork that's involved. They want to know if we can devise a system to track services and payments without as much paperwork.

DR. WEIKEL: I feel very strongly that this has to be one of our objec-

tives. Physicians are out there to treat patients. That's their principal function and they should not have inordinate paper burdens in order to participate in the program. At both the Federal and State levels we have to streamline paper requirements. We have to look at the possibilities of having some automated input from the physician's office into the system to eliminate some of the paperwork. I believe that we can do a much better job of reducing the paperwork than we're now doing.

QUESTION: There are many questions around the country about PSROs and utilization control. Is utilization control cost-effective?

DR. WEIKEL: Certainly some of the early experiments such as San Joaquin and Sacramento, where they did some parts of utilization control such as

preadmission certification, have shown that it clearly has been cost-effective. If we look at the CHAMP program in Massachusetts, if we look at the CHAP program in Sacramento—involving preadmission or concurrent admission review of hospital stays, it has been cost-effective. But we don't have all the answers about utilization control regulations or the PSROs. I think the cost-effectiveness will depend on how they're administered. I don't mean just controlling utilization but controlling and improving quality. That will really be the final determinant.

QUESTION: Do you think the Federal Government should spend more on the alternatives to institutional long term care of the elderly rather than so much on institutional care?

DR. WEIKEL: If we're able to demonstrate that we can care for a significant number of elderly people in environments other than institutions then I would certainly expect to see more use of alternatives to institutional care. But we should remember that some patients might be better off being institutionalized from a social-psychological point of view. If an individual doesn't have any contact with another human being, if she's living in an apartment alone and the only contact she has is with someone who brings in her meals, if she eats only once a day—that individual might be better off in an institution. The answer to that question can be determined only by having better data concerning the real needs of the elderly to determine whether they can be cared for as well or better in their homes—taking into account socialization, cultural, and economical problems.

QUESTION: Medicaid has always had a problem with the "notch." There are always people who are just beyond the level of eligibility, and it often seems unfair to them that lower income people are getting better medical care or more medical care than they can afford. Can anything be done about it?

DR. WEIKEL: Well, there's nothing we can do about it in the context of the present Medicaid law. Whenever you have a "notch" it's not fair. Many of our Federal programs have built in notches, and often they create disincentives for individuals who are slightly above that notch. I guess one of my most difficult tasks as Commissioner is looking at the correspondence coming in from recipients or from citizens around the country telling us that they are desperately in need of medical services. We have to write back to tell them that the Medicaid program cannot help them because they have an income slightly above the income level set by their State or that their State does not have a medically needy program, or that they happen to be a single adult or a married couple without children. The most difficult thing for me is to tell a couple that meet the income and assets test but have no dependent children that they are not eligible for the program.

QUESTION: How would you sum up the most important goals for Medicaid?

DR. WEIKEL: First, to improve program management so that we can control costs without curtailing services for people. Second, to advance the EPSDT program. Third, to detect, prevent, and eliminate abuse and prosecute real fraud when we find it.

I would also like to use the dollars we are spending in the Medicaid program to try to bring about positive change in the health care delivery system. For example, that may mean trying to encourage alternatives to the fee-for-service type of care most of our patients receive. We certainly want to encourage prepaid health programs and HMOs. We also want to improve the quality of services that are provided in nursing homes.

Together, these are the improvements we need in order to realize the potential of Medicaid. We have achieved a lot, but we want to do more. Come back in a few months and I'll tell you how we're doing.

Program Summary

MEDICAID

Expenditure Estimates in Billions

	FY '74	FY '75	
Federal	**$ 5.8**	**$ 6.2**	*(Congressional Appropriation)*
State/Local	**4.8**	**5.1**	
Total	**$10.6**	**$11.3**	

About 50% of the total is spent in 5 States, NY, CA, IL, TX, MI.

AUTHORIZING LEGISLATION: Social Security Act, Title XIX, as amended

PROGRAM BEGAN: 1966

WHAT IS MEDICAID? WHO IS ELIGIBLE? HOW MANY GET HELP? Medicaid is a federally-aided, State-administered program that pays for basic medical care for persons with low incomes who are aged, blind, or disabled or members of families with dependent children, and in some States, certain groups of other needy persons under 21. In FY '74, an estimated 24.3 million persons got help; in '75, an estimated 24.7 million.

WHICH STATES PARTICIPATE? All States except Arizona. DC, GU, PR, and VI also have programs.

WHAT SERVICES ARE PAID FOR? For those on welfare, every Medicaid program must cover at least these services: inpatient hospital care; outpatient hospital services; other laboratory and X-ray services; skilled nursing services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physician services. Federal funds are also available to support additional services like prescribed drugs, dental services, eyeglasses, care in intermediate care facilities, care for patients 65 or over in institutions for tuberculosis or mental diseases, etc.

HOW DOES MEDICAID WORK? Within Federal guidelines, States set their own standards for eligibility, fees paid to providers, and services offered. Federal aspects are administered by the Medical Services Administration/SRS which issues regulations and guidelines to govern conditions under which federal funding will be available.

HOW IS MEDICAID FINANCED? Federal, State, and sometimes local tax funds finance Medicaid. The Federal share is about 55% of the national total.

HOW IS MEDICAID ENFORCED? The law requires HEW to invoke financial penalties on States that fail to provide early and periodic screening, diagnosis, and treatment and family planning services for AFDC families, and to reduce Federal contributions to States that do not operate approved utilization control programs.

PROGRAM PRIORITIES:
Early and Periodic Screening, Diagnosis, and Treatment of Children Under 21.
Utilization Control and Medical Review.
Professional Standards Review Organizations.
Health Maintenance Organizations.
Alternatives to Institutional Long-Term Care.
Medicaid Quality Control.

SRS NEWSLETTER
Social and Rehabilitation Service
Volume 8 – No. 8 • May 30, 1975

SRS Aids Vietnam Refugees

SRS Deputy Administrator Svahn (kneeling) and Dan Sprague, Region IX Deputy Director, with Vietnamese children.

"It was sudden, totally unexpected. But dedicated people in SRS are getting the job done."

Deputy Administrator John A. Svahn thus described SRS's special mission at three military bases where thousands of Vietnam refugees wait to be settled across the U.S.

Nine Regional Offices have provided 135 staffers, including 3 Regional Commissioners, to assist in the processing of the repatriates and refugees. Involving all components in the regions, Regional Offices III and IV are responding to Eglin Air Force Base, Fla.; I, V, VI and VII to Fort Chaffee, Ark.; VIII, IX and X to Camp Pendleton, Cal.

"They are a most dedicated crew, all of them," said Deputy Administrator Svahn, just back from Camp Pendleton after helping to set up HEW's operating center there. "I saw something I didn't think existed anymore–a 24-hour working day, several as a matter of fact. Despite adverse working conditions morale is extremely high. There were no serious complaints about the unheated Quonset huts, field jackets and having to use blankets to keep warm while registering lines of refugees just off planes."

Mike Stevens, MSA, was the first civilian to arrive at the refugee sites, landing in Camp Pendleton at about the same time as the first refugees. SRS personnel from Region VIII, IX and X assisted in registering and processing 25,000 repatriates and refugees within the first 14 days. U.S. Marines built a tent city ("Little Saigon") for 18,000 refugees in 24 hours. More than 7,000 repatriates and their dependents and refugees have been processed and resettled.

There have been three shift supervisors at Camp Pendleton: Alex Ross and Les Freidman of Region IX; Mike Casey, Region VIII. Isabelle Davis, Acting

(Continued on page 3)

Administrator Leaves SRS

"SRS has come a long way in the past two years," former Administrator James S. Dwight, Jr., said in farewell comments last week.

"It has made far more progress than many of us working on the 'inside' realize."

Mr. Dwight, the third SRS Administrator, submitted his resignation in

(Continued on page 2)

Administrator Leaves SRS

(Continued from page 1)

April and is now leaving office to return to the field of public accounting. He will remain in Washington.

Deputy Administrator John A. Svahn will serve as acting Administrator until President Ford designates and the Senate approves a successor.

"I believe we proved that sound management of public assistance is fully compatible with having compassion for those in need of our services," Mr. Dwight added. "But more than that, this management style is necessary if we are to focus resources effectively to better meet the needs of eligible recipients. SRS employees can take some real pride, I believe, in the agency's progress. I don't think I am prejudiced when I say that SRS is among the most creative elements in the Department.

"Some employees, seeing the recent transfer of some bureaus from the agency, have asked whether SRS is going to last. I don't think you need be concerned on that point, because SRS is the achiever in HEW and it deals with the highest priority programs of the Department. That's not the kind of organization you break up.

"Because it handles programs involving nearly 30 million people and $25 billion in public funds, we can be sure SRS will always face problems. But, for the first time, we are diagnosing our problems—we are aware of what we have to do to meet problems. We also have an improved ability to identify problems earlier and to take appropriate action to keep them from becoming larger. We have also shown to ourselves and others that we can operate on a dynamic rather than a static basis. We have proven our ability to modify our plans and actions to meet particular needs.

"We have also improved our communication, not just within the Federal Government, but with the States and State Governors in particular. Our operational planning system has now become the basic management tool for SRS and I believe we now have meaningful involvement of both our bureaus and Regional Offices in the development of these operating plans.

"This progress is due not so much to my personal efforts as to those of SRS employees generally—at both the Central and Regional Offices. I think the future is bright in terms of opportunities for all SRS employees to participate constructively in meeting human needs."

With the news of Mr. Dwight's departure, the *SRS Newsletter* and others reviewed some of the activities in which he played a part:

"Improved management of AFDC has been one of Mr. Dwight's key objectives since his arrival," noted John A. Svahn, Commissioner of Assistance Payments Administration. "He consistently has been one of those who believe that the present welfare system can be made workable and efficient and he has steadfastly pursued that, with substantial success.

"The simplification of regulations, more effective work incentives, stronger child support and QC are all part of this effort," Mr. Svahn added.

"Much of the success of Quality Control must be attributed to Mr. Dwight's personal involvement in the program," said Fred Schutzman, Director, Office of Special Initiatives. "He 'sold' the program nationwide by briefings, speeches, written communication and visits to States and Regional Offices."

"The Federal presence, improved management of public assistance and the principle of accountability in all States are directly attributed to the positive steps taken by Mr. Dwight during his tenure in office."

The Title XX law of the Social Security Act grew out of extensive and cooperative actions under Mr. Dwight's administration, involving others in the Department, the Congress, the National Governor's Conference, and more than 40 organizations concerned with services for the aged, the blind, the disabled and children and their families.

CSA Commissioner John C. Young said: "I hope we all recognize that development, enactment and implementation of Title XX owe much to the continuing effort of Jim Dwight."

"Medicaid, with all its good works, has always had its share of problems. But during Mr. Dwight's tenure, Medicaid's outlook for program improvement has brightened," according to MSA Commissioner Keith Weikel.

In a number of areas MSA has moved decisively to realize the promise of the program, including EPSDT. The Department and Congress have strongly backed the efforts to reform Medicaid. Ninety new staff positions were authorized for MSA in FY '75 and 108 more positions have been requested in the budget for FY '76.

"With these new resources," said Commissioner Weikel, "progress toward better and more economical health care for the needy should continue."

Mr. Dwight, in his comments, said that he wanted to leave a final thought with SRS employees:

"You are a part of an organization that is viable, that is involved, which has a proven capacity to act, and which has more challenges ahead than behind it."

SRS
NEWSLETTER
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Social and Rehabilitation Service
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C.

ERNEST L. MATTHEWS, *Editor*

Room 5332 MES Bldg: (202)245-2457

Regional Roundup

Region III:

Sybil E. Shrier, Financial Assistant in the Philadelphia Office, recently received from Secretary Weinberger his Special Citation.

She is one of 10 HEW employees to receive the citation.

"The special dedication and outstanding contributions of those we honor exemplify what is best and most rewarding about service to the public," said Secretary Weinberger. 'It is a standard of excellence deserving of our greatest respect and sincerest gratitude."

A GS-7 with more than 20 years Government service, Ms. Shrier is one of the first employees below GS-9 to be nominated for the Secretary's personal award.

Mr. Weinberger invited SRS to nominate superior employees in grades GS-1 through GS-9 and the wage grade equivalents for the annual Secretary's Special Citation.

"All too often there is a tendency to somehow relate superior performance to only those employees in the upper grade levels," said Clarence M. Coster, Associate Administrator for Management. "But throughout SRS there are employees in grades GS-1 through GS-9 whose work is outstanding."

Ms. Shrier was especially cited for performing functions of two positions–simultaneously. Performing duties above her grade level, she contributed to the control and reduction of compliance issues guarding the possible misuse of Federal funds by State agencies.

This occurred at a time when Ms. Shrier knew she could not be given a promotion because of reorganization and freeze on promotions.

Region II:

A joint task force of State and Regional Office personnel has been meeting in New York City on a bi-monthly basis since February. Not only is it providing leadership in the implementation of Title XX in New York State, but it is reflecting the beginning of a changed working relationship between the State and the Regional Office.

"In the past," said Dr. Melvin Herman, Associate Regional Commissioner for Community Services, "the relationship had often shown the effects of on-going disagreements about retroactive claims and disapproval of plan amendments.

"The changed atmosphere is quite apparent," added Dr. Herman, "and we have every hope that this cooperative working relationship will continue as the State moves into its more formal planning period after the Title XX regulations have been published."

This task force has representatives from the State's program policy staff in its Department of Social Services, the Office of the Governor, the Bureau of the Budget. The Regional Office has representatives from program and management units.

Thus far, the task force has discussed the general approach which the State will pursue in developing its Title XX plan; identification of policy or legislative changes which the State may have to make; implications of several options which the State will have under the legislation, and phasing out current programs and the beginning of Title XX.

SRS Aids Vietnam Refugees

(Continued from page 1)

Chief of SRS Repatriate and Refugee Office, set up the Repatriate operation initially. Mrs. Davis was recently released from the Camp Pendleton hospital after ten days of treatment for a spider bite.

Region VII Commissioner Bob Davis was initially at Camp Pendleton but was sent on to assist Camp Chaffee and Eglin Air Force Base in setting up operations. Dan Sprague, Region IX Deputy Regional Director, is the senior HEW official at Camp Pendleton.

Both the Regional and Central Offices are receiving many inquiries on how refugees are to be resettled in local communities, responsibilities of sponsors, how income maintenance programs function and what Federal monies are available.

At least another 100,000 refugees are expected to arrive at the processing centers from Guam and other Pacific islands. Thousands of them remain at all three processing centers awaiting security clearance.

"Our biggest challenge," explained Mr. Svahn, "is assuring that these refugees are registered and that their sponsorship is valid. This is critical as SRS will have residual responsibility for them should their sponsorship break down.

"But I don't think much of that will happen," added Mr. Svahn. "Most of these people have strong ties with the U.S. They speak English well and most of them are skilled or professional people. Private industry continues to sponsor many of them. Their resettlement in local communities will create jobs rather than take over existing jobs."

"This special mission has a serious effect, for the time being, on the implementation of SRS priorities and programs," said Carolyn Betts, Assistant Administrator, OFO. "We made

(Continued on page 4)

SRS Office of Fie

Currently, one of the Office of Field Operations' principal–but unwritten–responsibilities is "helping Regional Commissioners retain their sanity," says Carolyn Betts, Assistant Administrator for Field Operations.

"New responsibilities," she added, "are emerging for Regional Offices–Title XX, Title IV-D and other programs. We are helping ROs tool up for this new work at the same time that we are also trying to steer them through the complexities of a substantial Regional reorganization. Now nine Regions are involved in the processing of repatriates and refugees from Vietnam."

These efforts call for close collaboration between Central Office components and all 10 Regional Offices.

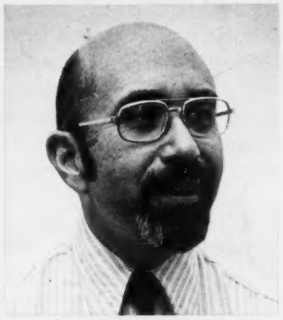
"For me," continued Miss Betts, "OFO's aims are simply stated: to bring Regional Offices and Central Office into a productive mode of interdependence which encourages each to fulfill it's assigned responsibilities in the most effective manner."

In immediate touch with the daily activities of 10 Regional Commissioners and their staff of 1,000 persons across the country, Miss Betts is the principal aide to the Administrator in the direction and management of Regional Offices.

"It's exciting," summed up Assistant Administrator Betts, "to be a part of both levels."

Directly assisting Miss Betts are Will Wolstein, Executive Assistant; Inez Yallery-Arthur, Secretary; the Division of Regional Implementations and the Division of Administrative Management.

"The challenge of the Executive Assistant's job comes from the wide range of activities we work in–spanning the whole gamut of SRS operations," said Mr. Wolstein. His responsibilities involve all aspects of OFO work, in addition to acting for Miss Betts in her absence.



Mr. Wolstein served in the San Francisco (IX) Regional Office from July to December of last year as both Acting Deputy Commissioner and Acting Regional Commissioner. He came to HEW in 1964 from New Jersey's State Child Welfare Program. Until he joined OFO in 1970 he had worked in the Children's Bureau and in Community

Standing squarely behind the current U.S. Savings Bond Campaign are (l-r) Michele Jefferson, APA; Susan Ley, Local 41; Clarence M. Coster, Associate Administrator for Management; Nancy Stipa and Cynthia Shanks, OM.

Refugees *(Cont. from page 3)*

the decision to hold off participation of Region II until dire necessity because of the numbers of Regional staff assigned to the New York Medicaid fraud investigations."

The other nine Regional Offices are now in the process of rotating staffers back to their Regional Offices and replacing them with new staffers.

Region I staffers involved in the processing operation at Fort Chaffee include Marla Kahn, MS; Elizabeth Willard, Secretary; Vincent DeNovellis, CS; and Sidney Hinkel, AP.

Region III (to Eglin Field): Joseph Coleman. AP; Harriet Truman, MS; Robert Ellis, CS; Sybil Schrier, OM;

ield Operations

Services Administration.

Samuel N. Guida is Acting Director of the Division of Regional Implementations.

"This Division," he said, "will continue to assist Central Office components and Regional Offices in the performance of their responsibilities."

This is done through (1) the improvement of communications (2) a clearer delineation of functions between Central and Regional Offices (3) and the encouragement of utilizing an integrated planning system with a more meaningful reporting system for proper accountability.

Mr. Guida is supported by Rod Locklear, Regional Office Representative for Regions–VI, VII and X; Charleen Tompkins, RO Representative for Regions I, II and III; Charles Gale, RO Representative for Regions IV and VIII; and Betty Fields, Secretary. Mr. Guida works primarily with Regions V and IX.

Prior to joining APA in 1967, Mr. Guida worked for the New Jersey Division of Mental Retardation. He subsequently worked for the Division of Public Welfare as Senior Field Representative, servicing the counties of Essex, Union and Ocean. With OFO since 1970, he served as Acting Regional Commissioner for Region X from November 1973 through May 1974.

Gene E. Ackley, Acting Director, Division of Administrative Management, said:

"One of our top priorities right now is to coordinate the SRS reorganization in all Regional Offices."

The Division has nation-wide responsibility for technical Regional management matters relating to organization, functions, authorities, position management, budget, fiscal reporting, administrative policies and procedures.

Mr. Ackley has been with OFO since it was formed with the establishment of SRS in 1967. Prior to then he served in administrative management positions in the Welfare Administration and the HEW Public Health Service.

Division staff includes Vernice Lee and Jack Bertron, Program Management Officers; Yvonne Newton, Secretary; and Williemae Dennis, a Stay-in-School Program employee.

Grace Teti, OM; and Eileen McMasters, Secretary.

Region IV (to Eglin Field): Regional Commissioner Virginia Smyth, Ed Reagan, AP; Betty McGinley, Secretary; Thad Godwin, CS; Ron Niswonder, Virgil Deshart, MS; Carita Womack, OM; Diane Wright, Secretary; Cathy Rhodes, Margaret Welch, Frank Inman, Pat Baker, Charles Newton, SI; Travis Holtzclaw, OM; Dee Bullard and Dorothy Kent, MS.

Region V (to Camp Chaffee): George Marchettis, SI; Anita Langham, AP; Wande Thomas, Secretary; David Schaeffer, MS; Helene Stoffey, Gerald Spatz and John Deale, SI.

Region VI (to Camp Chaffee): Regional Commissioner Floyd Brandon, Nancy Vaught, Secretary; Dudley Hall, Norma Mailer, Harold Blouch, AP; Homer Brannon, CS; Viola Cage, AP; Martha Mahoffey, ORC; Maynard Snell, SI; Jean McNabb, MS; Bob Jones, FM; Louise Fairchild, CS; Mark Adin, John Bednorz, SI; Jack Luehis, MS; Charles Yates, WIN; Bob Starks, OM; Ann Hargrove, Secretary; Lloyd Perry, OM; Janice Garrett, SI; Bob Bourassa, John Shater, Claudia Cox, OM; and Doris Shields, AP.

Region VII (to Camp Chaffee): Regional Commissioner Bob Davis, Max Kissue, SI; Howey Leroux, MS; Ralph Rogers, CS; Larry Leverentz, SI; John Harper, ADP; and Fred Redeker, SI.

Region VIII (to Camp Pendleton): Michael Casey, CS; Lauren Smith, MS; Ed Friesen, AP; and Mary White, Secretary.

Region IX (to Camp Pendleton): Les Freidman, AP; Alex Ross, CS; Rita Rhodes, OM; Audrey Barker, CS; Montsenate Brady, CS; Jean Le Masurier, CS; Carol Rosen, Lucky White, WIN; Fred Scheir, Toni DeLong, Lelitia Martinez and Mack Stans, SI.

Region X (to Camp Pendleton): Marilyn J. Devaney, SI; and Margaret Cunningham, MS.

At press time 18 staffers and one Deputy Regional Commissioner from Region III had also moved into Pennsylvania's Indiantown Gap Military Reservation to participate in processing additional refugees.

Personnel Matters

Have you ever wondered what happens to your application after you have submitted it to the personnel office for one of those promotion vacancy announcements?

Here's what happens:

Usually, merit promotion vacancy announcements are posted with specific opening and closing dates. Employees who believe they meet the qualifications and desire to be considered for the position may submit their application (SF-171) to the personnel office on or before the closing date of the announcement.

After the closing date all applications to that announcement are reviewed by a personnel specialist to determine if each applicant meets the minimum qualification requirements for that position. This is done by comparing the information you've presented on the application against the standards established by the Civil Service Commission.

It is *very important* at this point that you realize the value of preparing your application carefully to insure that you have included your most recent experience, education, training, outside activities and awards. It is again very important that you attach a copy of your most recent appraisal of performance.

If you don't have one, ask your supervisor about one. Generally speaking, the appraisal of performance will count quite heavily when it comes time to weigh all the factors being considered for selecting the best person for the vacancy.

After the personnel specialist has determined that you are eligible for the position you have applied for you will be notified in writing (notification is also made to those who do not meet the minimum requirements) that you are being further considered for the job. Your application is now---once again---going to be rated and numerically ranked along with all of the other candidates for the position. This time the rating and ranking will be performed by a Quality Review Board (QRB).

A QRB will usually consist of three persons selected from throughout the Agency, one of whom is selected because of his or her knowledge of the position you have applied for; the second, a minority group member or female employee; and the third, a union representative.

Remember, the information you furnish on your application is the only "picture" the QRB members will have of you. Make it good.

Upon completion of rating and ranking all applications by the QRB a list of the best qualified candidates and their applications are certified to the person who will be making the selection. Usually, three to five candidates are certified to the selecting official who in turn reviews the applications and makes arrangements for individual interviews.

Thus, with the information you provided on your initial application and the impression you make during your personal interview, the selecting official is now ready to make the final selection.

Here's hoping that you're the one.

---Jim Shields
×50276

German Visitors

HANDS ACROSS THE SEA---Dr. Helen Martz (left) introduces Frau Margot Kalinke (second from left), National Chairman of Women Workers of West Germany, to Mary Catherine Jennings of SRS International Activities. Looking on are Arthur Pogensky, SSA; and Frau Ursula Schloesser, leader of 50 other German social workers who recently visited SRS. Briefings were made by Dr. Martz, MSA; James Burr, CSA; Isabelle Davis, APA; and by Mr. Pogensky. This was followed by a "lively discussion" of public welfare, social services and social security delivery systems in both the United States and West Germany.

Medicaid Eligibility QC Confab

SRS staff and State representatives meet across the conference table to work out differences over the proposed Medicaid Eligibility Quality Control regulations. From the head of the table Fred Schutzman, Director, Office of Special Initiatives, chairs the meeting as Administrator Dwight observes (center, left).

As a forum for the exchange of ideas prior to finalization of the regulations, the discussions centered around the Quality Control process and implementation problems. Mr. Dwight stressed "the importance of having States' advice in the development of the system as well as the regulations."

Participants included Meg Copernoll and Joyce Jackson, MSA; William Hickey, NCSS; Dr. Lee Weisenborn, OIS; Carlton Stockton, Jack Knudsen and Dorthy Soltys, OSI; Ludwig Guckenheimer, APA; Gail Picker and Diana Murray, OS; members of the Division of Quality Control Management; Joyce Causey, Jack Jones and Sid Schneider, SSA; Iris Slack, APWA; and Bonnie Enneking, GAO.

State representatives included Wade J. Williams, California; Robert S. Wright, Nebraska; Neva V. Hell, Missouri; Robert G. Wessel and Wayne Hamberger, Illinois; Tom Corbett, Wisconsin; Alvin Thacker, West Virginia; and Faustine Martinez, Texas.

Moving Ahead

(A monthly column on information, training and opportunities for SRS women)

President Ford recently said in a memo to heads of Departments and Agencies:

Chairman Hampton of the Civil Service Commission recently reported to me on progress to assure equal opportunity in Federal employment.

I have also reviewed the most recent statistics on the employment of minorities and women in the Federal Government.

Minorities and women have demonstrated their ability to compete successfully under merit principles. Over one-fifth of the jobs in Government Agencies are held by Blacks, Spanish-speaking Americans, American Indians and Asian Americans.

Nearly one-third of all Federal employees are women.

While I am encouraged by these figures, our efforts must continue. For example, within the general schedule and similar grade groupings, minorities represent only 5.2 percent and women only 4.5 percent of Federal employees at GS-13 and above. I therefore want you to know how I view equal employment opportunity. I urge you to provide strong leadership in your own organization.

Our Nation's strength is based upon the concept of equal opportunity for all our citizens. Decisions motivated by factors not related to the requirements of a job have no place in the employment system of any employer and particularly the Federal Government.

But more is required than non-discrimination and prohibition of discriminatory practices. What is needed are strong affirmative actions to assure that all persons have an opportunity to compete on a fair and equal basis for employment and advancement in the Federal Government. Affirmative action includes recruitment activities designed to reach all segments of our society, fair selection procedures and effective programs of upward mobility so that all employees have the opportunity to gain skills to enable them to compete for higher level positions.

Such actions are under way in the Federal Government.

They must be continued and expanded.

Although the Federal Government has employed large numbers of minorities and women, vigorous efforts to assure equal employment opportunity must continue, particularly in those geographical areas and agencies and installations where more progress is needed.

. . . Moreover, men and women of all racial and ethnic backgrounds must be assured a fair opportunity to serve in positions where they can make a maximum contribution and participate in the decision-making process. . . .

----President Ford

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PLS: Parent Locator Service

Parent Locator Service is a key feature of the recently proposed regulations to implement the new Federal-State child support program.

As required by the law, the Parent Locator Service (PLS) is designed to provide information on the whereabouts of absent parents for the purpose of enforcing support obligations.

Title IV-D becomes effective July 1, 1975, when the Federal PLS as well as the State locator services would be in place. A computerized information exchange network will transmit information between States and PLS and between PLS and Federal Departments. States will be trained on the use of the PLS and computer terminals to send and receive information.

The PLS will receive requests for the last known home and employer's address of absent parents. If such information is contained in HEW files or files of other Federal agencies and the State has been unable to locate addresses using its own resources, PLS complies via the computerized information exchange network. Any fees for the use of the Federal PLS would be collected by the State.

Proposed regulations set standards which States must follow in locating absent parents, establishing paternity and obtaining child support payments.

"When these operations become fully effective," said Administrator Dwight, "we believe that about $1 billion annually in Federal and State AFDC tax funds can be saved."

Established last March within the Administrator's Office, the Title IV-D task force developed the proposed regulations and organization of the Child Support Enforcement Unit.

The task force members are Louis Hays, Steven Henigson, Darwin Perry, Frank Adamson, Joseph Betit, John Sacchetti, Tina Rosenblum, James Watson, Annette Turner, Marshall Mandell and Jack Summerfield.

Frances Jackson, OPRE, operates the lever of a double-deck parking machine. GSA is in the process of installing the new machines in the Switzer parking lot to alleviate the shortage of parking spaces. Training will be provided by the SRS Division of General Services on the proper use of the machines. Traffic in the lot is one-way only, from the entrance at 3rd Street to the exit at 4th Street. Official parking assignments are being reviewed.

The Administrative File

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for previous months. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the month of February 1975. (Abbreviations key: **PR**-Program Regulations; **PRG**-Program Regulations Guides; **PI**-Program Instructions; **IM**-Information Memoranda; **FSI**-Field Staff Information and Instruction Series; **AO**-Administrator's Office; **MSA**-Medical Services Administration; **APA**-Assistance Payments Administration; **CSA**-Community Services Administration; **RSA**-Rehabilitation Services Administration; **NCSS**-National Center for Social Statistics.

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, room 2620; AO reports, room G-115B; RSA reports, room 3126; APA reports, room 1232E; MSA reports, room 4094; and CSA reports, room 2010.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U. S. Department of Health, Education, and Welfare, 330 C Street S.W., Washington, D.C. 20201.

AO-IM-75-26: Cost Allocation-Requirement for PA (2/6/75)

AO-IM-75-27: Waiver of Life Safety Code (2/11/75)

AO-IM-75-28: Child Abuse and Neglect (2/12/75)

AO-IM-75-29: Implementation of New Utilizaton Control Requirements in · November 29, 1974 Reg (2/13/75)

CSA-PI-75-5: Review of State Services to Runaway Youths (2/12/75)

NCSS-OIS-75-5: 1975 AFDC Study (2/7/75)

RSA-PI-75-21: State Plan for VR Services for FY'76 under Title I of the Rehab Act of 1973 as amended by the Rehab Act Amendments of 1974 (2/3/75)

RSA-PI-75-21: Deadline for Submittal of Fiscal Year 1975 State Plan for VR (2/12/75)

RSA-PI-75-23: The Second (1975) Institute on Rehabilitation Issues. (Formerly the Institute on Rehabilitation Services) 2/20/75)

RSA-PI-75-23: Proceedings of the National Symposium on Employment of the Visually Impaired in Secretarial Fields (2/25/75)

RSA-IM-75-41: Training Grants under Section 203 and Section 400(a) (2) of the Rehabilitation Act of 1973, as Amended–FY 1976 (2/27/75)

MSA-IM-75-10: "Professional Health Provider Participation in the EPSDT Program under Medicaid" AMA Committee on Health Care of the Poor (2/3/75)

MSA-IM-75-11: Seventh Annual Conference of State Medicaid Program Directors (2/17/75)

MSA-IM-75-12: Guidelines for Implementing Utilization Review in Hospitals (2/17/75)

MSA-PIM-75-8: Medicaid Eligibility of Persons Receiving "Priority Benefits" in Lieu of Supplemental Security Income (SSI) Payments (2/5/75)

MSA-FSI-75-28: EPSDT Penalty Procedures (2/3/75)

MSA-FSI-75-29: List of Pages in Preprinted State Plan (2/3/75)

MSA-FSI-75-30: Draft Policy on Medical Care Equivalents to EPSDT for Review and Comment (2/13/75)

MSA-FSI-75-31: EPSDT Report Forms to be Used During FY 1975 (2/13/75)

MSA-FSI-74-32: Seventh Annual Conference of State Medicaid Directors (2/17/75)

MSA-FSI-75-33: Cost Reporting Forms for SNFs and ICFs (2/25/75)

MSA-FSI-75-34: State Plan Amendments (2/28/75)

Bringing Better Management to Medicaid

JAMES S. DWIGHT, JR.

If you work in the social welfare system you probably will have added a new phrase to your professional vocabulary by the time this article appears in print. The phrase is *Medicaid Eligibility Quality Control.*

This is the newest of the programs developed by the Social and Rehabilitation Service to help the 54 States and Territories better manage their responsibilities. This effort deals with the provision of medical services to the needy under the Medicaid program.

Most of that program (75 percent), which serves over 25 million people every year at a cost of about $13.5 billion, already falls within either the Quality Control System established for the Aid to Families with Dependent Children (AFDC) program or the Quality Assurance System established for Supplemental Security Income. We are now in midstream with the successful AFDC-QC effort and we know that it works because it tells us the extent of ineligibility and payment errors, the nature of those errors and what action is required to correct errors.

We are now bringing the same system to bear on the population in the Medicaid program it doesn't cover: the roughly 7 million persons receiving Medicaid services who do not receive public assistance cash payments—the medically needy.

This group is not subject to AFDC-QC review, and recent studies in the field both by the General Accounting Office and by SRS tell us that ineligibility there may run as high as 20 percent. If that figure is approximately correct, Medicaid ineligibility is costing in the neighborhood of $600 million a year in Federal and State funds. With States and their local jurisdictions paying just under half of Medicaid costs, that means expenditures for services to ineligible people of about $260 million in State funds and about $330 million in Federal funds every year.

At this time of economic pressures and budget restraints, better management will enable us to make better use of those funds.

Following field tests in California, Illinois, Maryland, and New York, SRS issued a proposed regulation which spells out how QC will be applied by the States to their Medicaid programs. This new regulation is scheduled to be finalized before this summer.

Before detailing how the new system will work, here is a brief background view of how Medicaid works and how the QC technology was brought into the administration of welfare programs.

Medicaid (Title XIX of the Social Security Act) provides medical assistance to families receiving AFDC payments and those eligible to receive these payments, and to most aged, blind, and disabled individuals who receive Supplemental Security Income (SSI) or supplemental SSI payments. Additionally, 29 States provide assistance to medically needy individuals and families who do not meet financial qualifications for AFDC or SSI, but whose income and assets fall below a State-designated eligibility level for Medicaid.

Generally, payments are made out of Medicaid funds to vendors (providers) of medical services, directly or through a fiscal agent, as the direct result of claims filed by the provider after services are rendered to a Medicaid recipient.

There has been a substantial improvement in the administration of the AFDC program during the past year attributable to the high priority given the quality control initiative and the commitment shown by States to improve management of their systems.

The experience gained from these successful Federal/State management initiatives can now be extended to the medically-needy program.

The proposed Medicaid Quality Control regulation is substantially the same as the quality control regulation for the AFDC program. Major provisions include the following:

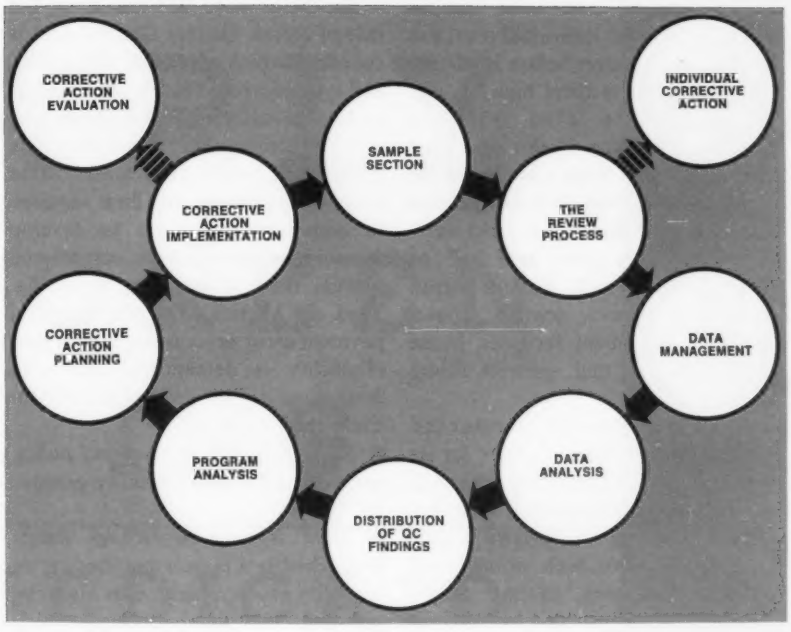
1. States would be required to submit to SRS data concerning payments made in behalf of ineligible recipients and data regarding recipient liability. This data would allow States to determine the amount of erroneous expenditures related to specific errors, to identify the cause of errors, and to help establish priorities and plan corrective action.

2. An initial sampling period of July 1 to September 30, 1975, would be established for the Medicaid Quality Control program. Commencing October 1, 1975, sampling periods would be of 6 months duration. The 3-month initial sampling period is designed to stagger this program from the AFDC quality control program in order to uniformly spread the workload.

3. The States would be required to submit corrective action plans after the end of each Medicaid sampling period.

But let's stop right here to make a big point: Our purpose is to improve agency administration of the eligibility process and reduce erroneous expenditures, nothing more and certainly nothing less.

Nothing in this new Medicaid QC program is aimed at the millions of needy persons now on the rolls who are eligible to be there! All eligible persons will continue to receive the medical services they need and this effort cannot infringe on that in any way.



When sampling begins July 1, the roughly 18,000 samples will be drawn each period only from the aforementioned 7 million persons receiving Medicaid who do *not* receive public assistance cash payments (the "medically needy" and others determined eligible by the States for medical assistance).

Note that AFDC-QC and the Supplemental Security Income review systems already cover most all who receive cash assistance.

When we sat down to design the actual Medicaid QC system, it was apparent that sampling could go one of two ways:

(A) We could sample the eligibility case rolls, or

(B) We could sample the Medicaid paid claims.

We chose alternative B because it would provide more statistically reliable results. Thus, samples for each period will be drawn from Medicaid paid claims. Review of each sampled paid claim, however, will require that the reviewer contact the person who received the medical service to determine eligibility. The reviewer also will determine whether any payments were made for medical services provided before the individual became eligible. (Each State has its own version of the

"spend-down" process which prescribes how an individual must use up existing resources before Medicaid will pay for his medical bills.)

The sample also will be stratified—meaning, in this case, that one-half of each State sample will be from Medicaid paid claims of general hospitals, mental hospitals, and nursing homes. The other half will be selected from such noninstitution sources as doctors, dentists, clinics and other outpatient facilities, home health agencies, and agencies filling prescriptions.

SRS has already conducted briefings and training sessions for its Regional Office personnel who will provide technical assistance when requested following QC reviews. Training manuals have been printed and technical assistance to the States already is being provided by SRS.

Findings of our own exploratory tests have been useful in helping States get ready for Medicaid Eligibility QC. HEW and General Accounting Office field studies have found these to be the major eligibility problems for Medicaid: patient's resources have not been verified, patient's eligibility has been renewed without rechecking his circumstances, payment for services has been made when Medicaid eligibility of the patient has never been determined. While these problem areas suggest where to look for trouble, they represent only a beginning. The actual sampling, beginning July 1, 1975, will provide the States with a wealth of additional information on which to base their planned corrective actions, just as similar sampling did for AFDC-QC in 1973-75.

But QC is more than measuring the rate of errors. Quality Control data is collected which classifies the nature and type of error. This wealth of information is analyzed to determine the cause of errors, where the most errors occur, and what they cost. State program managers are then required to determine how best to develop measures which will both correct and prevent those errors from occurring. Thus, the Medicaid QC eligibility and payment error process starts with how eligibility is determined and who determines it. The how and the who include these factors:

■ *State and Federal law and policy* establish and define eligibility groups.

■ *State Agency procedures* determine whether a person qualifies for an eligibility group; which needs are to be met and with what services; which resources and income are to be considered and how they are to be measured in eligibility determination; how to identify changes in circumstances which affect eligibility; and how all such information is to be submitted to and processed by the agency.

■ *Agency staff skill and accuracy* play a large role in carrying out tasks. Involved here are such elements as understanding of manuals and instructions, training and work experience, size of individual caseloads, distribution of staff within operating units, and organizational structure within the local agency.

■ *Recipient understanding, accuracy, and timeliness* in providing the agency with relevant information also are vital. This includes knowledge of requirements, willingness to share information, and ability to contact the agency about changing circumstances.

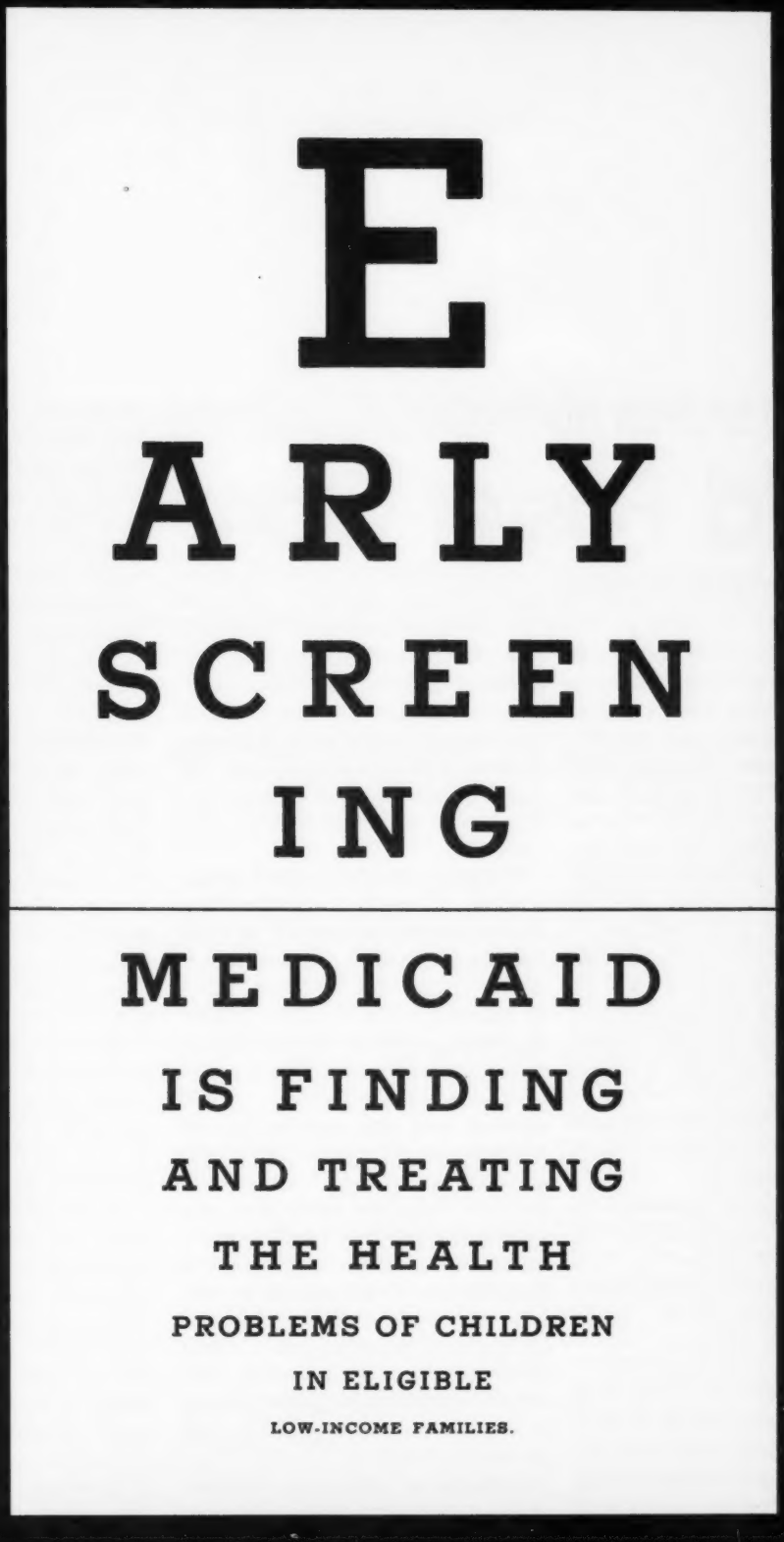
The State Agency Quality Control System is designed and operated so that these elements produce an eligible caseload. A statistically reliable sample of claims is drawn from which recipients are identified. Once completed, the reviews are tabulated and analyzed, reflecting current caseload error rates. The review also reveals the types and the specific nature of the errors.

The findings are then used to make administrative improvements. The improvements may affect State policies, eligibility determination procedures, agency performance, and client reporting. Their effect on caseload error rates will be evaluated by subsequent samples. Thus, QC becomes an ongoing process, providing continuing data on error rates, identifying error types, and evaluating corrective actions.

As a fully integrated system, QC becomes an administrative function of the State agency. The system's key components are depicted on the chart.

We believe the States will enter into this effort aggressively and efficiently because such an effort will mean millions of dollars saved through elimination of ineligibility and that means more Federal and State dollars available to help those who are truly in need—the eligible medically needy of this Nation.

Mr. Dwight is Administrator, Social and Rehabilitation Services.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A Search for New Methods

Child Foster Care

CAROL BENNETT and MARVIN WEISINGER

The magnitude of the foster care problem in America continues to increase. In 1965 New York City had 22,021 children in foster care. By 1971 the number had risen 12 percent, while the number of school children had risen only 6.4 percent. By 1971 the annual cost of providing foster care service in New York City was $132,825,953, an increase of 105 percent over the 1965 expenditures of $64.553,520.

Recognizing the need for detailed information on the whole foster care system, the Child Welfare Research and Demonstration Grants Program of SRS funded, in 1966, a 5-year longitudinal study of New York City's Foster Care System. The Columbia University School of Social Work conducted the study.

Intake and initial placement of children are the responsibility of the Bureau of Child Welfare of the NYC Department of Social Services and the Office of Probation of the Family Court.

Project Description

The Child Welfare Research Project consisted of three independent but parallel studies which focused on (1) the behavioral and intellectual characteristics of the sample children, (2) the characteristics of their families, and (3) the characteristics and attitudes of the agencies and social service workers serving them. In addition, separate studies on drug abusing mothers of children in foster care, the characteristics of foster parents, and the costs of foster care in NYC were conducted.

The study sample consisted of 624 children (from 467 families) who entered foster care in NYC in 1966. The children were followed for 5 years, whether they remained in care or returned home. Children entered the sample only when they had been in care at least 90 days. Children entering State training schools, mental hospitals, and institutions serving the retarded were not included. All sample children were entering foster care for the first time; no more than two children from any one family were included in the sample. Sampling was designed to ensure a balance of both sexes, since the child developement literature reports sex-linked differences for many assessment factors, including physical growth, motor development, mental abilities, and personality traits.

Family Court intervention remanded about 20 percent of the children to the system, while the Bureau of Child Welfare admitted the remaining 80 percent. About half of the children had been born out of wedlock, and only 13 percent lived with an intact family unit; 31 percent were white, 45 percent were black, and 24 percent were Puerto Rican.

The intellectual and behavioral characteristics of 392 sample children were assessed at entry, at 2½ years after entry, and at 5 years after entry. An additional 103 children completed testing on two of the three occasions. Intellectual status was measured by three age-appropriate, standardized intelligence tests: the *Cattell Infant Intelligence Scale, the Minnesota Preschool Scale,* and the *Wechsler Intelligence Scale for Children.* Several variables were studied to determine their relationship to change in intellectual status over time: (1) demographic variables, (2) reasons for placement, (3) maternal care variables, (4) characteristics of foster parents providing individual care, (5) characteristics of institutions providing group care, (6) length of time in care, and (7) number of replacement experiences.

Questionnaires to obtain data on behavioral status were constructed specifically for the research program; information on health, emotional, and developmental problems was gathered from clinical assessments, parent reports, caseworker profiles, and a history of each child's early development. Changes in behavioral status were correlated with variables similar to those used in studying change in intellectual status.

Agencies providing foster care services were studied to determine "agen-

cy investment," *i.e.*, the time and effort expended on behalf of sample children and their families beyond routine maintenance. Reporting for each child and family was done by at least two social workers. Nineteen indicators of agency investment were developed, including worker stability, size of caseload, worker training and experience, and intensity of activity in relation to the family. These measures of agency investment were compared to the following outcome variables, ranked in order of desirability: (1) discharge home under improved family conditions, (2) stable long term placement, (3) discharge home to an unchanged family situation, and (4) unstable long term placement.

A study of worker attitudes and professional training was conducted by reinterviewing 222 of the 511 social service workers originally interviewed in the study of agency investment. These workers were or had been employed by 41 public and private child welfare agencies in NYC. Findings are presented in the paper "Professional Training and the Child Welfare Worker: An Exploratory Study," available from project staff.

An analysis of the cost of foster care in NYC was conducted at the request of the NYC Bureau of the Budget. Cost factors were examined from the perspective of their implications for social planning and for the more rational organization of social service delivery. Cost analysis was restricted to per diem payments made from the Charitable Institutions Budget, including the cost of providing temporary foster care at the three public shelters financed through the Department of Social Services. Costs invested by the child care agencies themselves were not included, (most agencies contribute less than 5 percent of the total cost of care from their own funds), nor were administrative costs for intake, allocation, and continuing case supervision by the Bureau of Child Welfare. Costs are, therefore, conservative estimates of the actual cost of foster care in NYC.

SIGNIFICANT FINDINGS

Placement Outcomes

- The major reasons for placement were (1) mental illness of the child-caring person, 141 cases; (2) behavior of the child, 71 cases; (3) physical illness of the child-caring person, 69 cases; (4) parent unwilling to assume care, 42 cases; (5) parent unwilling to continue care, 69 cases; (6) neglect or abuse of child, 91 cases; (7) abandonment, 66 cases; and (8) family dysfunction, 59 cases.
- Discharge rates for 305 of 467 sample children 4 years after entry into the foster care system were (1) mental illness of the child-caring person, 64 percent; (2) behavior of the child, 82 percent; (3) physical illness of the child-caring person, 67 percent; (4) parent unwilling to assume care, 65 percent; (5) parent unwilling to continue care, 71 percent; (6) neglect or abuse of child, 59 percent; (7) abandonment, 52 percent; and (8) family dysfunction, 59 percent.
- The discharge rate from foster care was greatest early in placement. Of the 340 children discharged within the first 3½ years, 32 percent left within the first 6 months, 25 percent in the second 6-month period, 17 percent in the third, and 8 percent in the fourth.
- Of the 340 children who left care after 3½ years, 20 percent returned home to a stable, nuclear family; 55 percent were returned to a mother only, 2 percent to a father only, 6 percent to a grandparent, 7 percent to a relative, and 1 percent to a nonrelated person; 4 percent went to a hospital, training school, or had run away, and 5 percent were adopted.
- Of 44 children whose mothers were drug abusers, 70 percent remained in care after 3½ years.

Agency Investment and Staff Practice

- Agency investment (worker stability, experience, and caseload size) had little influence on family improvement during the first year of placement. In contrast, intensive work with the family seemed to have some bearing on the problem of improving the home situation in the second and third year.
- The family situation was improved in 50 percent of the families involved at the end of 4 years. A sample of 61 improved families showed 30 percent of improved family situations were attributable to worker effort, an overwhelming 48 percent to events clearly beyond the worker's control, and 22 percent to a combination of worker effort and external events.
- The proportion of children returned home increased directly with the intensity of contact with the service worker when family initiated.
- Of the workers involved in incare service, (in contrast to the intake worker), the incare worker with 5 or

more years of experience and some training has the most effect on the child's placement outcome.

■ Workers with large caseloads had as high a discharge rate as workers with small caseloads.

Workers typically took one action a month for each foster child, either directed to or concerning the child. Only children in institutions for the emotionally disturbed received regular weekly appointments.

■ Although the sample of 624 children was deliberately designed to exclude obviously adoptable infants and toddlers, 33 adoptable children were still present. Of these 33 children, 17 were likely candidates for adoption. Five had been surrendered and not yet adopted, and 12 had not had action taken to achieve abrogation of parental rights after 4 years. However, of the total sample of 624 children, there were 23 adoptions in the group not considered adoptable.

Costs

■ Institutional and group residential care are much more costly than foster family care; for fiscal year 1971, the monthly cost of institutional care was over $600, compared to about $300 for foster family care.

■ The average cost of providing substitute care for the average foster care child until he is 18 years old is $68,701.

■ The average cost of providing care to a child who returns home is $7,518.

■ The average cost of providing care to a child who is adopted is $5,486. This contrasts with a recent estimate of $25,560 as the 18-year cost of rearing a child for an urban family with two children in the 'north central region of the U.S., based upon a low cost estimate. Thus, the cost of foster care is about five times the expenses incurred by a family on a low cost budget which raises its own child. The cost of providing substitute care for an infant in foster care until he is 18 years old is $122,400.

■ More than $7 million had been expended for the 624 children in the sample at the point when they could have been in care for 4 years.

■ The cost for all placed children (not just sample children) in the 467 families included in this study was $11.8 million for the 4-year period.

■ It is estimated that, for the period 1966 to 1970, 100 families with children in permanent foster care would cost $14.6 million, 100 families with children in short term foster care would cost $2 million, and the cost of providing care to 100 children who were adopted would be $500,000.

Project Opinion

The NYC child welfare network is, in effect, isolated from the other systems that feed children into foster care. Further, a considerable degree of chance determines whether resources are appropriately mobilized. The system organization makes it easier to purchase costly institutional and foster care services for children than to spend money for restoration of families. This holds true even though expenditures for families produce considerable savings to the public treasury in the long run. Further, the system, as many social service systems in the United States, operates essentially without benefit of sound data available on a regular basis for decisionmaking. Therefore, the system renders accountability for the fate of children separated from their parents an impossible task.

The foster care system is far from optimally organized. Cases are not regularly reviewed to determine whether continued separation is the best solution for the child, the family, or the community. Moreover, cases are not systematically marked for special attention where there is evidence that an investment of skilled manpower could help the child or family.

Implications for Action

Placement Outcomes

■ Because of the nature of the precipitating problems (*i.e.*, mental illness, physical illness, abandonment, neglect, etc.) closer examination must be given to problems in the larger social service systems that necessitate the child's placement in the first place, and the possibility of pursuing other solutions for the precipitating problems (*i.e.*, more home care, more homemaking services, etc.).

■ The low discharge rate for children of drug abusing mothers raises the question of whether a move toward termination of parental rights should be made in these cases.

Agency Investment and Staff Practice

■ The necessary overlapping of responsibilities between the voluntary agencies and the Bureau of Child Welfare, the cited adoption problems, and the personal observations of the

researchers indicate that a reliable information system is needed to assist workers in their daily practice and decisionmaking.

■ The child's status in placement was linked to the employment stability of the workers in both intake and incare foster care agencies. The proportion of children awaiting long term placement was more than double for children whose worker changed. The proportion of children who returned home was markedly higher when the worker remained the same. Children in care for a relatively short time were affected by a change in workers similarly to those in long term care. During the first 8 months of the study, there was a 40 percent turnover of staff serving the sample children.

■ A stable, experienced social work staff directly affects placement outcome. Therefore, management practices conductive to maintaining a stable staff must be instituted. Studies concerning what makes agencies effective and efficient must be pursued.

■ The experience of this study suggests that some of the basic assumptions of casework practice are well worth examining in practice settings. These include size of caseload, intensity of contact, and worker influence in changing family behavior.

■ Rising service costs suggest that a strong inservice training course should be instituted concerning the economics of service delivery.

■ New and innovative methods to increase the number of adoptions are needed. Some suggested innovations include the use of TV advertising and subway placards, bounties for indigenous workers who find homes, and subsidies for quasi-adoptive homes, particularly for children from minority groups. All of these approaches represent investments that can lead to high rates of return. Another suggestion includes the use of specific homefinding workers to develop contacts with suitable adoptive homes. One successful adoption per year would more than compensate for the worker's annual salary.

■ Efforts at preventive and restorative intervention in families prone to disruption may well be justified on economic as well as humanitarian grounds, even though such services seem to be initially expensive.

Discussion and Limitations

The Child Welfare Research Program has clearly shown that foster care placements result from the dysfunction of the larger social system and from unmitigated social problems ranging from mental and physical illness, to the child's own behavior, to family dysfunction. Social service and health care programs are now operating in an attempt to deter every stated problem which currently ends in foster care placement. Yet in thousands of cases these programs fail, and the "last stop" system, foster care, must intervene at tremendous financial cost to society and emotional cost to the families and children involved.

Project researchers have recommended the design of a new service delivery system aimed at prevention. The potential effectiveness of this system must deal with the fact that 50 percent of this study's sample population were receiving public welfare services and, therefore, theoretically had access to some sort of intervention for their problems. However, they did not succeed in keeping their children at home. The feasibility of a program of prevention rests on determining whether these families did not receive help when it was asked for, did not seek help, or refused to accept help when it was offered. That 72 percent of the children in this study eventually returned home, although only 50 percent of the home situtations were improved, indicates a desire to remain intact despite severe social, medical, and economic obstacles.

Although the purchase-of-care system of NYC's foster care program is not the usual design for delivery of foster care services, and NYC is one of the highest foster care cost areas in the country, there is no reason to believe that the findings of this study are not applicable nationwide. In isolating the cumulative costs of long term foster care, the researchers have added the factor of money to the human factors that demand better decisionmaking in child welfare. Further work is needed to document the cost of alternative approaches to care such as the recommended intensive prevention program. An estimate of the cost of services needed to maintain an en-

vironment stable enough to support a family should include public assistance payments, homemaker services, rent supplements, ongoing counseling services, and medical and/or psychotherapeutic services.

Findings from certain aspects of this longitudinal study need further analysis and replication before they can be disseminated to the field for action. For example, the predictors of vulnerability to long term placement developed in the study and published in *Child Welfare* are still tentative. In addition, although large-scale analysis of findings from behavioral and intellectual assessment of the sample children are presented by project staff, the results are not reported here since the original method and extent of analysis leave room for alternative interpretation of the data. A large amount of data from this phase of the project is currently being analyzed and interested readers are referred to project staff for further information.

Impact

This descriptive, longitudinal study of foster care for children in New York City will provide baseline data for a generation of researchers to come. Findings from the Child Welfare Research Program helped support the development of several innovative programs in New York City's foster care network. In 1972 a system of incentive payments was devised for increasing the availability of desirable exits from foster care. To increase returns home, New York City is now paying private agencies $400 for each child discharged home after more than a year in foster care; the $400 is being used by the agencies to prepare the family for the child's return. In addition, incentive payments of $1,000 are made to agencies for each hard-to-place child adopted, if the number of these adoptions arranged in a year is greater than the agency's previous 3-year placement record.

Findings from the Longitudinal Child Welfare Research Program have been widely disseminated. A conference entitled "Foster Care: Research Findings and Implications for Policy and Practice" was sponsored by the project and held October 29 through November 1, 1972, in West Point, New York. The following topics were discussed: client evaluation of foster care, foster care experience and the cognitive development of children, placement patterns, and agency and community perspectives. Each presentation was followed by a group discussion on the policy and practice implications of the findings presented. Findings on drug abusing mothers with children in foster care were presented at the Annual Meeting of the American Public Health Association, November 16, 1972, in Atlantic City, New Jersey.

Further, *Dollars and Sense in Foster Care of Children: A Look at Cost Factors*, by David Fanshel and Eugene Shinn, was cited in legislative testimony and resulted in several legislative changes concerning expenditures for foster care at the Federal, State, and local levels, including one of the few portions of the welfare reform legislation which became law. In April 1972, the New York State Assembly Select Committee on Child Abuse, chaired by Assemblyman Peter J. Costigan, repeatedly cited this publication in a report requesting large appropriations for foster care.

Of long range significance is the continuing work on the creation of a management information system for NYC's child welfare network. As components of this system become operational, NYC's ability to plan services on a firm, factual basis will be strengthened. New child care planning procedures have also been devised. When each child has been in care 6 months, agencies now submit plans highlighting those services needed to effect the child's return home. Both the management information system and the new child care planning procedures are furthering NYC's management goal of identifying children at crucial moments during their stay in foster care.

Analysis of data from the full 5 years of the Child Welfare Research Program is currently underway. The final results will be published during the next 2 years as they become available. The implications drawn from preliminary findings show the critical need for policy and legislative action to examine the existing social system.

Ms. Bennett and Mr. Weisinger were consultants for this project to the Regional Rehabilitation Research Institute, University of Florida, Gainesville, under whose auspices this report was prepared with SRS funding support.

Reports listed below may be obtained from the grantee or contractor:

BEYOND SHELTER—THE BROADER NEEDS OF LOWER-INCOME FAMILIES (11-P-57111/9-03 W.O.). California Health and Welfare Agency. Report prepared by Division of Research and Assistance, Department of Housing and Community Development, 1807 - 13th St., Sacramento, Calif. 95814. This project was to provide home management training to low income families making the transition from rental to home ownership.

NATIONAL SERVICE REFORM PROJECT (11-P-57308/8-01). Department of Social Services, State of Utah. National Services Reform Project, Department of Social Services, Room 221, State Capitol, Salt Lake City, Utah 84114. This project focussed on the centralization of fiscal agents, establishment of cost allocation and cost sharing procedures, an automated payments system and more feasible use of fiscal support staff.

HOSPITAL UTILIZATION OF AN HMO-ENROLLED MEDICAID POPULATION (97-P-00010/3-02). Temple University, Comprehensive Health Services Program Research and Evaluation, 3701 North Broad St., Philadelphia, Pa. 19140.

PADEC—AN EVALUATION OF AN EXPERIMENTAL REHABILITATION PROJECT (12-P-5644). The Disability and Health Economics Research Section, The Bureau of Economic Research, Rutgers University, 165 College Ave., New Brunswick, N.J.

KNOWLEDGE UTILIZATION RESOURCES AND PRACTICES OF VOCATIONAL REHABILITATION MANAGERS—Rehabilitation Monograph No. 7 (12-P-55142). Rehabilitation Research Institute, Box 208, J. Hillis Miller Health Center, University of Florida, Gainesville, Fla. 32610.

SOCIAL REHABILITATION AND POVERTY—THE CLEVELAND INNER-CITY PROJECT (12-P-55205). Vocational Guidance and Rehabilitation Services, 2239 E. 55th St., Cleveland, Ohio 44103.

CASE FINDING IN THE DEVELOPMENT OF MODEL FOR A COMPREHENSIVE COMMUNITY SYSTEM OF SERVICES FOR MODEL CITIES RESIDENTS WITH HEARING DISABILITIES (14-P-55249/7-01). Greater Kansas City Hearing and Speech Center, Kansas City General Hospital and Medical Center, 24th and Cherry, Kansas City, Mo. 64108.

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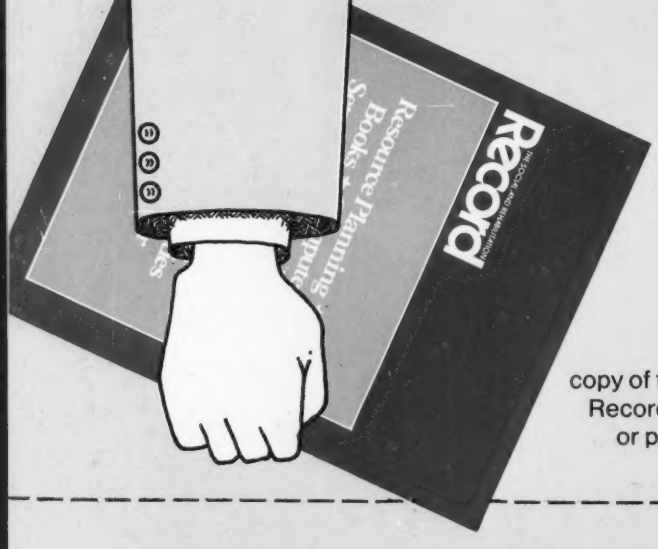

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